CITY OF STAMFORD
HEALTH CARE PROGRAM ENROLLMENT/CHANGE FORM

Benefits Department (203) 977-4070 or 977-4038

PERSONAL INFORMATION

LAST NAME	FIRST NAME	M.I.	SEX	MARITAL STATUS: ☐ Married ☐ Single
			☐ M ☐ F	EMPLOYMENT STATUS: ☐ Active ☐ Retiree ☐ COBRA

STREET ADDRESS	CITY	STATE	ZIP	TELEPHONE	ENROLLMENT TYPE:
				(H)_____ (C)_____	☐ New Hire ☐ Add Dependents ☐ Other Changes

Social Security Number	CHANGE TYPE: ☐ Change Address ☐ Change Name	QUALIFYING EVENT	UNION AFFILIATION
___ ___ ___ - ___ ___ - ___ ___ ___ ___	☐ **Delete** Dependents ☐ **Add** Dependents	_____	
EFFECTIVE DATE / /	☐ **Drop coverage**	QUALIFYING EVENT DATE: / /	

EMPLOYEE AND FAMILY INFORMATION - Please list yourself and all eligible dependents to be enrolled. Eligible dependents include your spouse and/or children. Children can be covered until the end of the month in which they reach age 26.

	LAST NAME, FIRST NAME, M.I.	DATE OF BIRTH	SOCIAL SECURITY #	SEX	DEPENDENT STATUS	PRIMARY CARE PHYSICIAN #	PHYSICIAN'S FULL NAME
☐ SELF					N/A		
☐ SPOUSE					N/A		
☐ SON ☐ DAUGHTER					Does this dependent have access to health insurance other? ☐ Y ☐ N		
☐ SON ☐ DAUGHTER					Does this dependent have access to health insurance? ☐ Y ☐ N		
☐ SON ☐ DAUGHTER					Does this dependent have access to health insurance? ☐ Y ☐ N		
☐ SON ☐ DAUGHTER					Does this dependent have access to health insurance? ☐ Y ☐ N		

I elect to enroll/disenroll in the coverage listed above and have chosen to enroll/disenroll the aforementioned dependents. I understand that this election is binding and cannot be changed until the next Annual Enrollment Period unless I experience a change in Family Status as outlined under Section 125 of the Internal Revenue Code. I hereby authorize my employer, The City of Stamford, to deduct the negotiated cost of this coverage from my paycheck. I agree and understand that my eligible dependents include my spouse and my biological, adopted and/or step children until their 26th birthday provided they do not have access to medical coverage through their own or their spouse's employment.

Signature:_____ Date:_____

Office Use Only

____Ceridian ____Cigna ____Davis ____Delta ____ Excel ____Medco H.R. Approval_____ Date:_____

Following documents were reviewed to verify dependent eligibility: _____Marriage Certificate, _____Birth Certificate Other(s) _____

_____Reviewed by _____, Date_____ _____